# CITY OF SCOTTSDALE 2005/2006 BENEFITS ENROLLMENT FORM

| | |
|---|---|
| ☐ New Enrollment<br>☐ Change in Enrollment<br>☐ Dependent Change<br>☐ Termination of Coverage | Qualifying Event: _____<br>Qualifying Event Date & Effective Date: _____ |

| FOR HUMAN RESOURCES USE ONLY | Received on: |
|---|---|
| ____ Original to Medical File _____ Copy to Payroll on: _____<br>____ Copies to Billing File _____ COBRA Notice Sent _____ DP Change Copy to MSIM | |

| Enrollee Last Name | First Name, MI | Employee Number or Social Security Number |
|---|---|---|
| Date of Birth | Home Phone | Work Phone |

## MEDICAL

☐ **AETNA OPEN ACCESS EPO** (408)
☐ **MAYO HEALTH TRADITION PPO** (410)
☐ **AETNA OPEN CHOICE PPO** (418)
☐ WAIVE MEDICAL
If you are a full time employee, you must provide proof of other coverage

**LEVEL of COVERAGE**
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

## DENTAL

☐ **ASSURANT HMO DENTAL** (425)
Enrollee's Dental Facility ID# _____
☐ **DELTA DENTAL PPO DENTAL** (420)
☐ NO DENTAL

**LEVEL OF COVERAGE**
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

**SUPPLEMENTAL LIFE INSURANCE**
You may apply for new coverage or changes at any time. Forms are located at www.ScottsdaleAZ.gov/jobs/benefacts

**CANCER & CRITICAL CARE COVERAGE**
For enrollment or changes call Colonial Life & Accident 1-800-845-7330

**AETNA LONG TERM CARE**
For enrollment or changes call Aetna Long Term Care 1-800-537-8521 or www.aetna.com/group/scottsdale

## ALTERNATIVE MEDICINE

☐ ALTERNATIVE HEALTHCARE OPTIONS (431)
☐ NO ALTERNATIVE MEDICINE

**LEVEL OF COVERAGE**
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

## ENHANCED VISION

☐ EYEMED VISION CARE (432)
☐ NO ENHANCED VISION

**LEVEL OF COVERAGE**
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

## SHORT TERM DISABILITY

WEEKLY BENEFIT (430)
☐ NO SHORT TERM DISABILITY
☐ $100/week (01)
☐ $200/week (02)
☐ $250/week (03)
☐ $300/week (04)
☐ $350/week (05)
☐ $400/week (06)
☐ $500/week (07)
(Short Term Disability Coverage cannot exceed 70% of your weekly salary)

## HEALTH CARE SPENDING ACCOUNT (455)

☐ NO
☐ YES Designate Annual Amount: $_____ (Maximum $3,000 per year)

## DEPENDENT CARE ASSISTANCE PLAN (460)

☐ NO
☐ YES Designate Annual Amount: $_____ (Maximum $5,000 per year)

**TWO SIDED FORM – BE SURE TO COMPLETE REVERSE SIDE**

# CITY OF SCOTTSDALE 2005/2006 BENEFITS ENROLLMENT FORM

**DEPENDENTS (LIST ALL DEPENDENTS TO BE ENROLLED)**

| | | | |
|---|---|---|---|
| **Spouse Name** (Last, First MI) ☐ Add ☐ Delete | Date of Birth | | Gender |
| Spouse is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision | | | |
| **Domestic Partner's Name*** (Last, First MI) ☐ Add ☐ Delete | Date of Birth | | Gender |
| Domestic Partner is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision | | | |
| **Dependent 1 Name** (Last, First MI) ☐ Add ☐ Delete | Date of Birth | Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child | Gender |
| Dependent 1 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision | | | |
| **Dependent 2 Name** (Last, First MI) ☐ Add ☐ Delete | Date of Birth | Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child | Gender |
| Dependent 2 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision | | | |
| **Dependent 3 Name** (Last, First MI) ☐ Add ☐ Delete | Date of Birth | Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child | Gender |
| Dependent 3 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision | | | |
| **Dependent 4 Name** (Last, First MI) ☐ Add ☐ Delete | Date of Birth | Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child | Gender |
| Dependent 4 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision | | | |

Additional dependents may be listed on a separate page.

**AUTHORIZATION:** By execution of this enrollment form, I understand that I may not change the election except in the event of a life change or during open enrollment. I authorize the City of Scottsdale to make the necessary before-tax and after-tax payroll deduction(s). I also understand that I am responsible for reimbursement to the City for any benefit amount paid to me/for me in advance of my payroll deduction. By my signature, I certify that the information on this form is true and correct, and that the listed dependents are my legal dependents.

Signature _____ Date _____

HR Signature_____ Date _____

***DOMESTIC PARTNERSHIP COVERAGE**

In addition to all other rules and conditions of city insurance coverage, the following apply to domestic partners coverage: In order for an enrollee to enroll a domestic partner for insurance coverage, both the enrollee and the domestic partner must complete the Domestic Partnership Affidavit. City of Scottsdale Human Resources must approve the affidavit prior to the commencement of coverage. Those with affidavits already on file do not have to resubmit. The portion of the insurance premium paid by the enrollee for domestic partner and children of the domestic partner is paid on an after-tax basis. The portion of the premium paid by the City for domestic partner and children of the domestic partner is reported to the Internal Revenue Service as taxable income to the enrollee. City enrollees who have domestic partnership insurance coverage are required to complete a Termination of Domestic Partnership form within 30 days of the termination of the domestic partnership. Children of a domestic partner may enroll for coverage only if the domestic partner is enrolled for coverage.

**QUALIFIED LIFE STATUS CHANGES**

You may not make changes to your benefit plans until the next open enrollment unless you experience a qualified life status change such as the birth of a child, marriage or divorce. If you experience a qualified life status change, you may add or cancel dependents but you may not change plans. You must notify HR within 30 days of a qualifying life status change. It is your responsibility to notify HR when a dependent (spouse/domestic partner or child) is no longer eligible for coverage. Failure to cancel an ineligible dependent from your coverage within 30 days will make you responsible for any claims incurred by an ineligible dependent and may result in disciplinary action up to and including termination.